CONFIDENTIAL **I. PERSONAL HEALTH REPORT** **CONFIDENTIAL**

To be completed by Student/Faculty

Year_____ ☐ Fall ☐ Spring Date of Birth: _____

Name_____
Home Phone E-mail Address

Home Address_____
& Street City State Zip

Address while attending NCCC **(if same as above, write "SAME"):**

_____
& Street City State Zip

Person to Notify in Case of Emergency:

_____
Day Phone Evening Phone Relationship

Address_____
& Street City State Zip

Family Physician: **(If none please write in none)** _____
Name Phone Number

Physician's Address: _____
& Street City State Zip

CONFIDENTIAL **II. PERSONAL HISTORY** **CONFIDENTIAL**

Place an "X" in the appropriate box (es):

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/shortness of breath
- ☐ Back Problems
- ☐ Bleeding Disorders
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Bowel Problems
- ☐ Broken bones/joint dislocations
- ☐ Chest pains on exertion or deep breathing
- ☐ Chronic cough/bronchitis/ bloody sputum
- ☐ Chronic pain in
  - ☐ neck ☐ arms
  - ☐ back ☐ legs
  - ☐ shoulders ☐ other
- ☐ Chronic skin problems (rash, infection)
- ☐ Concussion (within last yr)
- ☐ Continuing use of alcohol, drugs, or medicines
- ☐ Depression
- ☐ Diarrhea (recurrent)
- ☐ Difficulty urinating/burning or pain on urination/ frequency in urinating.
- ☐ Digestive Problems
- ☐ Dizziness/Fainting
- ☐ Ear Trouble
- ☐ Eye Trouble
  - ☐ Glasses
  - ☐ Contact Lenses
- ☐ Food Intolerances
- ☐ Frequent nausea or vomiting
- ☐ Headaches/ migraines (recurrent)
- ☐ Hearing Problems
  - ☐ Hearing aid
- ☐ Heart Defect/Disease
- ☐ Heartburn/GERD
- ☐ Hepatitis
- ☐ Hernia
- ☐ History of diabetes
- ☐ IBS
- ☐ Immune System Disorder
- ☐ Joint disease (injury)
  - ☐ pain
  - ☐ swelling } w/o injury
  - ☐ stiffness
- ☐ Kidney Disease
  - ☐ Infection
  - ☐ Stones
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Mental Illness or disorder
- ☐ Motion Sickness
- ☐ Pneumonia
- ☐ Problems w/ teeth
  - ☐ dentures
  - ☐ bridge
- ☐ Serious sprains/weakness of muscles
- ☐ Seizures
- ☐ Severe injury to head/ chest/internal organs
- ☐ Severe menstrual cramps/bleeding
- ☐ Sinusitis
- ☐ Sore Throat (frequent)
- ☐ Thyroid trouble
- ☐ Traumatic Brain Injury
- ☐ Tuberculosis
- ☐ Ulcerative Colitis / Crohn's
- ☐ Other (specify):

_____

_____

If checked <u>any of the above</u>, please explain below. Be specific. Use additional paper if necessary.

_____

_____

_____

Please list any allergies to foods, drugs, etc._____

_____

Do you take any medications regularly? ☐Yes ☐No If "Yes", please list drug(s) and dosage(s) _____

_____

Please list any serious injuries, illnesses, fractures, dislocations and surgery:_____

_____

(PERSONAL HISTORY CONTINUED ON NEXT PAGE)

Do you have any disability or impairment of which we should be aware? ☐Yes ☐No
If "Yes", please explain: _____

_____

Are you currently receiving treatment at a clinic or by a physician (other than regular checkups)? ☐Yes ☐No
If "Yes", please explain: _____

_____

Are you or have you ever been under the care of a psychologist, psychiatrist or psychiatric clinic? ☐Yes ☐No
If "Yes", please explain: _____

Date of last Tetanus/Diphtheria/Pertussis booster-Tdap (must be within 10 years) _____

RELEASE AUTHORIZATION

NURSING STUDENTS / FACULTY ONLY **CONFIDENTIAL**

I affirm that I have completed Sections I and II of the Health Report completely and accurately. By signing this form, I hereby authorize NCCC to disclose, as needed, any and all of my health-related records to: clinical and community facilities and agencies that I will be assigned to; College program faculty, staff and administrators who have legitimate educational interest in this information; and emergency and other medical personnel in a medical or medical emergency situation. I also assume full responsibility for my participation in clinical and community experiences, releasing the College from any and all liability. I further understand that if at any time during the semester my health conditions change or I am involved in an accident that affects my ability to provide care, I will notify NCCC Records Office immediately.

_____ _____

Date: _____

Name (Please Print) **Required** Student / Faculty Signature **Required**

Physician's Evaluation

Please print or type all information. Thank you.

CONFIDENTIAL **III. PHYSICAL EXAMINATION** **CONFIDENTIAL**

PPD Test must be completed every 12 months: 2 step PPD below-

Step 1. Tuberculin Skin Test (PPD) Date: Administered_____

Date Read_____Results _____ Read by_____

Step 2. Tuberculin Skin Test (PPD) Placed 7 days **after** first PPD**, no later than 21 days**. Date: Administered_____

Date Read_____ Results _____ Read by _____

(Must be read in mm induration, not simply as negative or positive)

➔ SIGNATURE AND TITLE OF HEALTH CARE PROFESSIONAL READING THE PPD (MANTOUX):

_____ _____ _____

Signature/Title Date Name *(please print)*

Address_____

Phone Number (with area code) _____

If positive, a chest x-ray must be provided Date: _____ Results: _____

Did patient have treatment for the positive skin test? ☐Yes ☐No

Drug:_____ Date started:_____ Date completed:_____

B. FOR ALL APPLICANTS — CONFIDENTIAL

Name of student: _____ Date of Birth:_____ (mm/dd/yyyy)

★ PHYSICIANS: Please complete **ALL** sections of this form. **It cannot be accepted unless completed.**

Sex: ☐Male ☐Female	Height:	Weight:	Blood Pressure:

CLINICAL EXAMINATION Check each item in proper column.	**NORMAL**	**ABNORMAL**	**NOTE:** Give details of each abnormality. Enter N.E. if not evaluated.
Metabolic Endocrine System			
Musculoskeletal System			
Neuropsychiatric System			
Abdomen / Pelvic			
Respiratory			
Cardiovascular System			
Gastrointestinal System			
Head			
Neck			
Eyes			
Ears			
Nose			
Throat & Teeth			
Breasts			
Genito-Urinary			
Extremities			
Skin			

RECOMMENDED:

Lab tests at Physician's discretion:	***Hemoglobin or Hematocrit:***	***Urinalysis:***	***Other:***

Is this student able to participate in all physical activity to include one or more of the following: Clinical Hospital Experience, Extended Wilderness Trips and Camping Experiences, Physical Education, Intramural or Intercollegiate Sports Competition.
☐Yes ☐No If "No" what activities are to be eliminated?

_____

Is there (or has there ever been) evidence of anxiety or emotional instability?
☐Yes ☐No If so, please indicate how the College may be of help to this student.

_____

After considering the history and physical examination, what is your professional opinion of this applicant's ability to meet the physical and emotional demands of college life?

_____

Do you recommend further investigation or treatment?
☐Yes ☐No If "Yes" please explain.

NAME OF EXAMINING PHYSICIAN (PLEASE PRINT)		PHONE	
STREET	CITY	STATE	ZIP
➔ **SIGNATURE OF PROVIDER**		**DATE**	